STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 58639

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 09/14/20 and concluded 09/16/20.	F 000		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of the facility's nursing staff schedule and staff interview, the facility failed to provide the services of a registered nurse (RN) for eight consecutive hours a day, seven days a week, for two days of the 38-day period from 08/09/20 to 09/16/20. Failure to ensure sufficient, qualified nursing staff are available on a daily basis has the potential to affect all the residents residing in the facility. Findings Include: The facility provided a copy of the nurse's schedule for the time period of 08/09/20 to	F 727	1) All residents residing at WHCC had the potential to be affected by not having an RN scheduled on 9/12/2020 and 9/13/2020 for 8 consecutive hours. All current schedules were reviewed by the DON to ensure an RN is scheduled for 8 consecutive hours 7 days per week. 2) All residents that reside at WHCC have the potential to be affected. 3) Before the schedule is distributed to the nursing staff, it will be reviewed by the scheduler & the DON. The schedule will	10/8/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/08/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	**1104 HWY 12 HETTINGER, ND 58639**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 1 09/19/20. A review of the schedules showed the facility lacked the required RN coverage for two days in September, on the 12th and 13th. During an interview on 09/16/20 at 07:40 AM, an administrative nurse (#1) confirmed the facility lacked an RN working eight consecutive hours on the days of September 12-13, 2020.	F 727	then be sent to the Administrator for final approval. 4) Audits will be performed by DON/designee bi-weekly X2, monthly X2, and quarterly X3 to determine if an RN was scheduled for 8 consecutive hours 7 days per week. Audit results will be reported at the monthly board meetings, monthly QAPI meetings, and quarterly QA meetings by DON/designee. 5) Completion date 10/8/2020.	